AMERICAN HERITAGE LIFE INSURANCE COMPANY
CANCER COVERAGE WITH OPTIONAL RIDERS CLAIM FORM

Submit Claims to:
American Heritage Life Insurance Company
1776 American Heritage Life Drive, Jacksonville, FL 32224

Fax 1-877-594-1416

For questions regarding the policy benefits, the supporting documentation, or for assistance with a claim, please contact our **Customer Care Center** at **1-866-232-1517** or visit our website at **https://oshr.nc.gov/document/ncflex-cancer-insurance-documents.**

To have claim benefits automatically deposited into the Policy/Certificate Holder's bank account, please complete and send our Direct Deposit form (ACH form). This form can be found on our website at **www.allstatebenefits.com** or **mybenefits.allstate.com**.

This form is designed as a communication tool to assist the examiner in reviewing the claim for available benefit. Please complete this form in its totality and complete one form per claimant.

Incomplete or blank responses may result in a delay in processing the claim request.

POLICY/CERTIFICATE HOLDER AND CLAIMANT INFORMATION: This information helps us to identify the policy, covered members, mailing address and employer to ensure benefits are being considered under the correct Coverage.

COVERAGE NUMBER(S): ____________________

POLICY/CERTIFICATE HOLDER INFORMATION: First Name: ____________ MI: ____ Last Name: ____________

Last 4 of Social Security #: XXX-XX-________ Birth Date: ________ Age: ______ Gender: ____________

Mailing Address: ______________________________ Apt#: ________

☐ **Check here if address is new** City: ____________________ State: ________ Zip: ________

Phone #: ____________ E-mail: ____________________

CLAIMANT INFORMATION: (If different) First Name: ____________ MI: ______ Last Name: ____________

Date of Birth: __________ Age: ______ Gender: ________ Relation to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Domestic Partner ☐ Other ____________

CLAIM DETAILS: Please provide the following claim details. This information is very important as it tells the examiner the specific details of the claim and helps the examiner determine whether benefits are available. The Diagnosis/Condition is the condition that was diagnosed by the physician.

What are your Diagnoses/Condition(s) for this claim (list all): ____________________

When did you first notice symptoms of your condition? ____________________

Have you ever had the same or similar condition? ☐ Yes ☐ No If yes, when? ____________________

What was the date of your initial pathology report? (please provide a copy of the report*) ____________
**For Clinical Diagnosis, submit lab results and medical imaging*

Other Conditions affecting your health: ____________________

When was your first physician visit for this condition? ____________ Most Recent Visit: ____________ Next Visit: ____________

Were you hospitalized due to this condition? ☐ Yes ☐ No Admission Date: ____________ Discharge Date: ____________

What is your current treatment (Chemotherapy/Radiation/Immunotherapy)? ____________________

Other Treatment/Therapy? ____________________

Frequency of Treatment: ____________________ Duration of Treatment: ____________________

ASSIGNMENT OF BENEFITS (Not applicable in New Hampshire)

I request that American Heritage Life Insurance Company send benefits to someone other than me. Please send available benefits to the name and address shown below.*

Name: ____________________ Address: ____________________

Provider Tax ID #: ____________________ ____________________

Relationship: ____________________ Signature: ____________________ Date: ____________

***Please be advised that if the claimant is covered by MEDICAID, we may be required to Assign Benefits (except disability) to Medicaid or the provider of service in accordance with State and Federal Regulations.**

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CLAIMANT'S NAME: ______________________________ **DATE OF BIRTH:** ______________

COVERAGE NUMBER(S): ______________________________ **CLAIM NUMBER:** ______________

INSTRUCTIONS FOR REQUESTING AVAILABLE BENEFITS:

- Benefits may vary by product and/or state. In addition, all the available Riders may not have been purchased and/or all the benefits listed may not be available. Please refer to the Coverage Document and Riders for specific benefits available. An outline of benefits is available on page 3 of the Coverage Document.
- Available benefits are considered in accordance with your specific Coverage, including all terms, conditions, provisions and applicable limitations and exclusions.
- Please select the benefits that may be due based upon the condition, services provided, and Coverages available.
- Please submit the supporting documentation. This documentation should include the claimant's name, diagnosis, and date(s) of service.
- If asked to provide a bill as supporting documentation, please request an itemized bill, UB04 or HCFA 1500 from the provider.
- Medical records may include but are not limited to: physician's office visit notes, hospital records, emergency room records, diagnostic test results, radiology reports, therapy visit notes, or physician consultation notes.
- We reserve the right to request additional information for review of the claim.

☐ **NEW CLAIM or** ☐ **CONTINUED CLAIM**

CANCER COVERAGE & RIDER BENEFITS: All benefits listed may not be available. Please refer to the Coverage Document and Riders for specific benefits available.

BENEFIT (IF APPLICABLE)	**SUPPORTING DOCUMENTATION**
ALL CLAIMS REQUIRE PROOF OF INITIAL DIAGNOSIS OF CANCER OR SPECIFIED DISEASE *	Pathology Report for Initial Biopsy, Excision, or Surgery *For Clinical Diagnosis, Submit Lab Results and Medical Imaging*
☐ **Continuous Hospital Confinement** ☐ **Inpatient Drugs and Medicine** ☐ **Physician's Attendance**	Hospital Bill with Diagnosis (UB04) or Itemized Hospital Bill and Hospital Admission and Discharge Summaries
☐ **Government or Charity Hospital**	Hospital Admission and Discharge Summaries
☐ **Private Duty Nursing**	Itemized Bill from Nursing Provider and Hospital Bill with Diagnosis (UB04) or Hospital Bill and Hospital Admission and Discharge Summary
☐ **Extended Care Facility** ☐ **At Home Nursing** ☐ **Hospice Care**	Itemized Bill from Extended Care, Nursing Facility, Home Health Provider, or Hospice Provider and Hospital Bill with Diagnosis (UB04) or Hospital Bill and Hospital Admission and Discharge Summary for the Preceding Confinement
☐ **Radiation** ☐ **Chemotherapy**	Itemized Bill with Procedure Codes or Drug Names and Charges (EOBs from primary insurance carrier are required for those policy benefits based on actual cost)
☐ **Blood, Plasma and Platelets**	Itemized Bill with Diagnosis
☐ **Surgery and Anesthesia**	Surgeon's Bill with Procedure Codes or Surgery Name, and Pathology Report and/or Operative Report, and Anesthesia Bill
☐ **Ambulatory Surgical Center**	Itemized Hospital or Surgical Center Bill and Pathology Report or Operative Report
☐ **Bone Marrow / Stem Cell Transplant**	Physician's Bill with Procedure Codes or Surgery Name
☐ **Second Opinion**	Itemized Physician's Bill
☐ **Ambulance**	Itemized Bill for Ambulance Services and Hospital Bill with Diagnosis (UB04) or Itemized Hospital Bill and Hospital Admission and Discharge Summary
☐ **Non-Local Transportation**	Listing of Dates Traveled with Roundtrip Mileage or Receipt/Itinerary for Air fare or Bus fare and Itemized Bills for Covered Treatment during Dates of Travel

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CLAIMANT'S NAME: ______________________ **DATE OF BIRTH:** ____________

COVERAGE NUMBER(S): ______________________ **CLAIM NUMBER:** ____________

CANCER COVERAGE & RIDER BENEFITS: (Continued). All benefits listed may not be available. Please refer to the Coverage Document and Riders for specific benefits available.

BENEFIT (IF APPLICABLE)	SUPPORTING DOCUMENTATION
☐ **Family Member Lodging and Transportation**	Listing of Dates Traveled with Roundtrip Mileage or Receipt/Itinerary for Air fare or Bus fare and Hospital Bill with Diagnosis (UB04) or Hospital Bill and Admission and Discharge Summary for Inpatient Confinement
☐ **Outpatient Lodging**	Itemized Bill/Receipt for Lodging Cost and Itemized Bills for Radiation or Chemotherapy on Dates of Lodging
☐ **Physical Therapy** ☐ **Speech Therapy**	Itemized Bill for Therapy, Referral with Diagnosis and Therapy Notes from Treatment Sessions
☐ **New or Experimental Treatment**	Itemized Bill for Cost of Experimental Drug/Treatment and Clinical Trial/Study Protocol for Treatment
☐ **Prosthesis**	Itemized Bill with Charges for Prosthesis and Operative Report showing surgical implantation
☐ **Anti-Nausea Drugs**	Itemized Bill/Receipt
☐ **Wavier of Premium for Cancer**	Attending Physician's Statement and Employer's Statement
☐ **Wellness Screenings**	Itemized Bill, Receipt, Results with Test Name and Date of Service. ☐ Biopsy for Skin Cancer ☐ Blood Test for Triglycerides ☐ Bone Marrow Testing ☐ CA125 (Cancer Antigen 125 – blood test for Ovarian Cancer) ☐ CA15-3 (Cancer Antigen 15-3 blood test for Breast Cancer) ☐ CEA (Carcinoembryonic Antigen - blood test for Colon Cancer) ☐ Chest X-Ray ☐ Colonoscopy ☐ Doppler Screen of Carotid Arteries ☐ Doppler Screening for Peripheral Vascular Disease ☐ Echocardiogram ☐ EKG - Electrocardiogram ☐ Flexible Sigmoidoscopy ☐ Hemocult Stool Analysis ☐ HPV (Human Papillomavirus Vaccination) ☐ Lipid Panel (total cholesterol count) ☐ Mammography, including Breast Ultrasound ☐ Pap Smear, including ThinPrep Pap Test ☐ PSA (Prostate Specific Antigen – blood test for prostate cancer) ☐ Serum Protein Electrophoresis (test for Myeloma) ☐ Stress Test on Bike or Treadmill ☐ Thermography ☐ Ultrasound screening of the Abdominal Aorta for Abdominal Aortic Aneurysms

PROVIDERS: Please list all Providers the claimant has seen in the past 2 years including the providers treating this Condition**.**

1. ______________ ______________ ______________
Attending Physician's Name: Address: Phone #:

______________ ______________ ______________
Specialty Dates Consulted: Reason for Visit / Condition

2. ______________ ______________ ______________
Primary Care Physician's Name: Address: Phone #:

______________ ______________ ______________
Specialty Dates Consulted Reason for Visit / Condition

3. ______________ ______________ ______________
Other Physician/ Specialist Name: Address: Phone #:

______________ ______________ ______________
Specialty Dates Consulted Reason for Visit / Condition

4. ______________ ______________ ______________
Hospital Name: Address Phone #:

______________ ______________
Dates Hospitalized: Reason for Hospitalization / Condition:

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CLAIMANT'S NAME: ______________________ **DATE OF BIRTH:** ______________
COVERAGE NUMBER(S): ______________________ **CLAIM NUMBER:** ______________

ATTENDING PHYSICIAN'S STATEMENT: To be completed and signed by the Attending Physician

SECTION #1: DESCRIBE THE CONDITION:

ICD 9/10 Code: ____________ Primary Diagnosis: ______________________

ICD 9/10 Code: ____________ Secondary Diagnosis: ______________________

Other Condition(s): ______________________

When did symptoms first appear? ______________________ If applicable, what was the Accident Date? ______________________

Has the patient ever had the same/similar condition? ☐ Yes ☐ No If yes, when? ______________________

Is the condition due to injury or sickness arising out of the patient's employment? ☐ Yes ☐ No

Pregnancy or Complication of Pregnancy: Due Date: ____________ Delivery Date: ____________ ☐ Normal Delivery ☐ C-Section

SECTION #2: TREATMENT REQUIRED:

First consultation: ____________ Most recent consultation: ____________ Next consultation: ____________ Released: ______________

Is/Was a Surgical or Medical Procedure Required? ☐ Yes ☐ No Date: ______________ Procedure Code: ______________________

Procedure: ______________________

Is/was Hospitalization required? ☐ Yes ☐ No Admission Date: ______________ Discharge: Date ________________

Hospital: ______________________ City: ______________________ State: __________

What is the Current Treatment Plan? ______________________

____

SECTION #3: RESTRICTIONS, LIMITATIONS AND ABILITY TO WORK: Please provide specific details/dates and understand responses such as "no work", "totally disabled", "undetermined" or "unknown" will not enable us to evaluate your patient's claim for benefits and may result in us having to contact you for clarification

The patient **IS ABLE** to work in the following capacity: ☐ No Work, ☐ Sedentary, ☐ Light, ☐ Medium, ☐Heavy, ☐ Very Heavy

The patient **IS UNABLE** to perform their job duties: ☐ Yes ☐ No If Yes, (Dates): From: ____________ Through: ____________

When is the patient expected to **RESUME WORK**? (Dates) Part Time/Partial Duties: ____________ Full Time/Full Duties: ____________

The patient **IS UNABLE** to: ☐ Stand ___Hours; ☐ Sit ___Hours; ☐ Walk ___Hours; ☐ Lift ___Pounds; ☐ Carry ___Pounds; ☐ Drive ___Hours;

☐ Type; ☐ Reach ☐ Kneel ☐ Squat ☐ Climb ☐ Crawl

Please provide the specific **RESTRICTIONS**: ______________________

Please provide the specific **LIMITATIONS**: ______________________

The Restrictions and Limitations are: ☐ Temporary: (How long? ________________) or ☐ Permanent

What **CLINICAL** or **DIAGNOSTIC FINDINGS** support these Restrictions and Limitations? ______________________

____

SECTION #4: REFERRING PHYSICIAN:

Name: ______________________ Specialty: ______________________

Address: ______________________ Phone #: ______________________

SECTION #5: ATTENDING PHYSICIAN VERIFICATION:

I am aware that it is a crime to fill out this form with facts I know are false or to leave out facts I know are relevant and important. I certify that the answers given on this form are true, complete and correctly recorded.

Physician Signature: ______________________ Date: ____________________

Print Name: ______________________ Specialty: ________________ Phone #: ________________

Address: ______________________ City: ____________________ State: _____ Zip Code: _______

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CLAIMANT'S NAME: ____ **DATE OF BIRTH:** ______________

COVERAGE NUMBER(S): ____ **CLAIM NUMBER:** ______________

EMPLOYER'S STATEMENT: To be completed and signed by the Employer

☐ Check here if you are Self Employed, then complete and sign this form.

☐ Check here if you are Unemployed. Please provide the last date you worked ____________and prior employer's name then sign this form

SECTION #1: EMPLOYMENT INFORMATION / JOB DESCRIPTION:

Name of Employer/Company: ____

Date of Hire: ____________ Employee's Job Title/Position: ____
*Please attach a copy of the job description or list major job responsibilities.

Major Job Responsibilities: ____

This Job Classification is: ☐ Sedentary, ☐ Light Work, ☐ Medium Work, ☐ Heavy Work, ☐ Very Heavy Work.

Prior to inability to work, they worked _________ hours per week. Hourly Pay: $____________ Annual Salary: $______________

If you are self-employed, we may require proof of income. We will notify you if additional documentation is required.

SECTION #2: DATES MISSED WORK / RETURNED TO WORK:

I hereby certify that ________________________ did not perform any part of his/her work from ____________ through ____________

Has the employee Returned To Work? ☐ Yes ☐ No Part time/Partial duties(date): _________ Full time/Full duties(date):__________

Did the employee work part time/partial duty? ☐ Yes ☐ No Dates: ____

Is part time/partial duty work available? ☐ Yes ☐ No Reason: ____

When recovered, will he/she resume work? ☐ Yes ☐ No Reason: ____

SECTION #3: WORKERS' COMPENSATION / OTHER DISABILITY COVERAGE / CONTINUED PAY:

Is this a Work Related Condition/Injury? ☐ Yes ☐ No Worker's Compensation Begin Date: ____________ End Date: ______________

Workers' Compensation Carrier: ________________________________ Benefit Amount: $____________(Monthly/Weekly)

Is the employee covered under any Other Disability Policy/Coverage through the Company?* ☐ Yes ☐ No

Other Disability Insurance Carrier: ________________________________ Benefit Amount: $____________(Monthly/Weekly)

Does this policy Replace any prior Disability Policy/Coverage through the Company?* ☐ Yes ☐ No

Prior Disability Insurance Carrier: ________________________________ Benefit Amount: $____________(Monthly/Weekly)

Effective Date: __________ Termination Date:_________ Maximum Benefit Period: ____________ Elimination Period: ______________

***We may require proof of other disability coverage or prior disability coverage for review.**

Continued Pay: Group Short Term Disability and Long Term Disability only:

Is the insured receiving Continued Pay, Salary Continuation, Sick or Vacation Pay? ☐ Yes ☐ No

Pay Period From Date	Through Date	Amount	Source of Income
____________	____________	______________	______________________
____________	____________	______________	______________________
____________	____________	______________	______________________
____________	____________	______________	______________________

SECTION #4: Section 125 / Employer Paid Premium : If yes, FICA withholding will be deducted from the disability claim payment.

Section 125: Were the premiums for this disability income policy/certificate paid with Pre-Tax Dollars under a Section 125 Plan? ☐ Yes ☐ No

Employer Paid: Were premiums for this disability income policy/certificate Employer Paid? ☐ Yes ☐ No

SECTION #5: EMPLOYER VERIFICATION: Check here if ☐ **Self Employed** or ☐ **Unemployed**

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Signed by: ____________________________ Print Name: ____________________________ Date: ______________

Title: ____________________________ Company: ____

Address: ____ Phone #: ____________________________

Other Comments: ____

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CLAIMANT'S NAME: ________________________________ **DATE OF BIRTH:** ______________

COVERAGE NUMBER(S): ________________________________ **CLAIM NUMBER:** ______________

CERTIFICATION: The Certificate/Policy Holder or Claimant who completed the claim, form please read and sign below.

I acknowledge the receipt of the Department of Insurance Claim Fraud Statements provided with this claim packet. I have read the notices and I am aware that it is a crime to fill out this form with facts I know are false or to leave out facts I know are relevant and important. I certify that the answers given on this claim form are true, complete, and correctly recorded. **Please also remember to sign and date the attached authorization required to process your claim.**

Signature:______________________________ Print Name: ______________________ Date: ____________

FRAUD WARNINGS BY STATE

NOTICE IN ALASKA, ARKANSAS, KENTUCKY, LOUISIANA, MAINE, NEW JERSEY, NEW MEXICO, AND VIRGINIA: Any person who knowingly and with intent to injure, defraud or deceive an insurance company files a claim containing false, incomplete or misleading information may be prosecuted under state law.

NOTICE IN DELAWARE, IDAHO, INDIANA, MINNESOTA, AND OKLAHOMA: Any person who knowingly and with intent to injure, defraud or deceive an insurance company files a claim containing false, incomplete or misleading information is guilty of a felony.

NOTICE IN ARIZONA: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

NOTICE IN CALIFORNIA: For your protection, California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

NOTICE IN COLORADO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

NOTICE IN DISTRICT OF COLUMBIA: FRAUD NOTICE: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

NOTICE IN FLORIDA: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

NOTICE IN MARYLAND: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NOTICE IN NEW HAMPSHIRE: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638.20.

NOTICE IN NEW YORK: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

NOTICE IN OHIO: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

NOTICE IN OREGON: Any person who makes intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law.

NOTICE IN PENNSYLVANIA: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

NOTICE IN PUERTO RICO: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or file, assist or abet in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars ($5,000), not to exceed ten thousand dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

NOTICE IN TENNESSEE AND WASHINGTON: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

NOTICE IN TEXAS: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

NOTICE IN WEST VIRGINIA AND RHODE ISLAND: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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CLAIMANT'S NAME: ______________________________ **DATE OF BIRTH:** ______________
COVERAGE NUMBER(S): ______________________________ **CLAIM NUMBER:** ______________

AUTHORIZATION TO RELEASE INFORMATION TO AMERICAN HERITAGE LIFE INSURANCE COMPANY

I hereby authorize any physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, health care provider, Pharmacy Benefit Manager, insurance company, the Medical Information Bureau (MIB) or other organization, institution or person that has any health related records or knowledge of me or minor dependents to disclose the entire medical record (excluding psychotherapy notes and in MAINE and VERMONT HIV related test results) to American Heritage Life Insurance Company (AHL), its duly authorized representatives, its subsidiaries or its reinsurers. This authorization extends to any minor dependent on whom insurance is requested or claim for benefits is being made.

The information to be obtained shall include insurance claim history from any Prescription Drug Database, pharmacy benefit manager, ambulance, insurance company, medical transport service, or the MIB. Also, I authorize any entity, person, or organization that has these records about me, including but not limited to my employer, employer representative and compensation sources, insurance company, financial institution or governmental entities, including departments of public safety and motor vehicle departments, to give any information or record it has about me, my employment, employment history or income to AHL.

I understand that this information will be used to evaluate and administer my claim for benefits or to evaluate my eligibility for insurance. I understand that there is a possibility of redisclosure of any information disclosed pursuant to this authorization and that information, once disclosed, may no longer be protected by certain federal regulations governing privacy and confidentiality, though it may still be protected by state privacy laws or other applicable privacy laws. I also authorize AHL or its reinsurers to make a brief report of my health information to MIB.

This authorization shall remain in force for 24 months following the date of my signature below or termination of my coverage, whichever occurs first. A copy of this authorization is as valid as the original. I or my legal representative may request a copy of this authorization. I understand that I may revoke this authorization at any time by sending a written notification to: **Attn: Privacy Officer, American Heritage Life Insurance Company, 1776 American Heritage Life Drive, Jacksonville, FL 32224.**

I understand that a revocation of this authorization is not effective if AHL has relied on the protected health information or has a legal right to contest a claim under an insurance policy or to contest the policy itself. The revocation will not apply to any information AHL requests or discloses prior to AHL receiving my revocation request. If I choose not to sign this authorization or if I later revoke it, I understand that AHL may not be able to process my application for coverage, or if coverage has been issued, AHL may not be able to administer my claim for benefits and this may result in a denial of my claim for benefits or request for services.

Claims submitted on dependents 18 and older require an authorization signed by the dependent.

______________________________ ______________________________
Claimant/Applicant's Signature Date Signed (mm/dd/yyyy)

______________________________ _________XXX – XX-______________
Claimant/Applicant's Printed Name Last Four Digits of Social Security Number

If signed by the legal representative, please describe the authority under which the representative is authorized to act and enclose any related documentation granting authority.

______________________________ ______________________________
Signature of Legal Representative Relationship

______________________________ ______________________________
Print Name of Legal Representative Date Signed (mm/dd/yyyy)

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